New Jersey Department of Health and Senior Services
AIDS Drug Distribution Program (ADDP)
PO Box 722
Trenton, NJ 08625-0722

INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR PARTICIPATION IN THE AIDS DRUG DISTRIBUTION PROGRAM

Before you begin completing the application form, please take a few minutes to review these specific instructions. While many of the questions are self-explanatory, some require additional clarification to be completed correctly.
If you need assistance completing this application, call toll free 1-877-613-4533.

SECTION I - PERSONAL INFORMATION

Question 3 - Enter your principal place of residence. Seasonal or temporary residence in New Jersey, of whatever duration, does not constitute residence. The residency requirement states that you must be a resident of New Jersey for at least 30 days prior to the date of this application.

Question 7 - Include two (2) proofs of residency which are current and dated. The date must be clearly visible and no more than six (6) months old. Sample proofs of residency include:

- Motor Vehicle Records (e.g., Valid Driver's License)
- Social Security Form # 2458 or Third Party Query Form
- Landlord's records and rent receipts
- Public utility records and receipts (electric, gas, phone bill)
- Personal property assessment records
- Bills of business or professional people (doctors, department stores)
- Post Office records
- Records of social agencies, public or private
- Employment records

Question 8 - Include proof of citizenship, or, if a legal alien, include a copy of your Alien Registration Card. Some examples of proof of citizenship include:

- Birth Certificate
- Passport
- Voter Registration Card

Question 9 and 10 - Failure to provide Social Security Number(s) will delay the processing of your application.

MARITAL STATUS:
Question 12 - Check "separated" if:

(1) You and your spouse live apart **AND** if you do not have access to, or receive support from, your spouse's income; OR
(2) Your spouse has been confined to a long-term care or psychiatric institution for at least 30 days prior to this application.

If you check separated, contact ADDP at 1-877-613-4533 for an Affidavit of Separation.

HOUSEHOLD SIZE:
Question 14 - In calculating the number of people in the household, include:

(1) Yourself, spouse (if married), AND
(2) All persons whom you claim as dependent OR All persons who claim you, the applicant, as their dependent.

SECTION II - HOUSEHOLD INCOME

Question 15 - Enter your **TOTAL HOUSEHOLD INCOME** by category, for last year and for this year.

Enter your income.
If you are married, enter your income **PLUS** your spouse's income.
If you are dependent on others, also enter their total income.

Fill in ALL of the blanks. List gross figures unless otherwise indicated. If your income for any category is zero, write "0" in that space.

If you and/or your spouse have Medicare Part B premiums deducted monthly from your social security check, multiply this amount by 12 (annual amount) and enter it under "Sources of Income." Most individuals who are permanently disabled or over 65 have Medicare Part B deducted from their Social Security check.

Examples of income which must be included under "Additional Income" are:

- Retirement Benefits/Annuities
- Palimony/Alimony Payments
- Realized Capital Gains
- Royalties
- Disability Benefits
- Business Income (Net)
- Inheritance
- Death Benefits Received (Net)

Maximum Allowable Household Income Limits for this Program effective March 1, 2003. Income limits are updated in March each year in accordance with federal poverty guidelines. If you need current income limits, call 1-877-613-4533.

Number of Persons in Household	Maximum Allowable Household Income
1	$44,900
2	60,600
3	76,300
4	92,000
5	107,700

For households with more than 5 persons, add $15,400 for each additional person.

Question 16 - If you or any member of your household filed a Federal, State and/or City Income Tax Return last year, a copy of each completed and signed tax return, including any and all attached schedules, must accompany your application.

Question 17 - If you have applied for Social Security Disability benefits, forward a copy of your Notification of Social Security Disability Entitlement, once received.

SECTION IV - INSURANCE COVERAGE

Question 21 - Check all that apply regarding your health insurance coverage. If you have "Private Health Insurance" through any source, provide the policy number(s) as well as name and address of the insurance carrier(s). If this coverage is provided by an employer (current or previous) or union, enter the name and address of the employer or union. "Private Health Insurance" includes the health insurance provided by private insurance carriers such as Blue Cross/Blue Shield, HMO, PPO, etc.

You must include a photocopy of the front and back of your insurance card(s).

SECTION V - CERTIFICATION AND AUTHORIZATION BY APPLICANT

The Certification and Authorization must be dated and signed (or marked) by you, your spouse (if married) and the preparer of the form (if other than the applicant). Anyone other than the applicant who prepares the form must provide his/her name and telephone number, in case questions should arise concerning your application.

CERTIFICATION BY PHARMACIST

You must make an agreement with a New Jersey Medicaid/PAAD participating pharmacist to dispense FDA-approved AIDS-related drugs on your behalf.

Complete the requested information in Section I and forward to your pharmacist for completion of Section II. Make sure that all requested information has been clearly entered. Ask your pharmacist to return the completed form to you.

Return the completed certification to the AIDS Drug Distribution Program along with your completed Application.

CERTIFICATION BY PHYSICIAN

Complete the requested information in Section I and forward to your physician for completion of Section II. Make sure that all requested information has been clearly entered. Ask your physician to return the completed form to you.

Return the completed certification to the AIDS Drug Distribution Program along with your completed Application.

BEFORE YOU MAIL YOUR APPLICATION:

- Attach copies of two (2) different proofs of residency.
- Attach documentation of U.S. citizenship.
- If you are a legal alien, attach a copy of your Alien Registration Card.
- Attach copies of completed and signed Federal, State and/or City Income Tax Returns, including any and all attached schedules.
- If you are receiving Social Security Disability benefits, forward a copy of your Notification of Social Security Disability Entitlement.

IMPORTANT: Send copies of any requested documents. Do not send original documents as they **WILL NOT** be returned.

- Attach the completed Certification by Pharmacist form.
- Attach the completed Certification by Physician form.

New Jersey Department of Health and Senior Services
AIDS Drug Distribution Program (ADDP)
PO Box 722
Trenton, NJ 08625-0722

APPLICATION FOR PARTICIPATION IN THE AIDS DRUG DISTRIBUTION PROGRAM

Please print clearly and answer all questions. Review the attached instructions before you begin. If you need assistance completing this application, call toll free 1-877-613-4533. Mail the completed application to the ADDP Program at the address given above. Send copies of any requested documents. Do NOT send original documents as they WILL NOT be returned.

How did you hear about the program?

☐ Doctor ☐ Pharmacist ☐ Case Manager ☐ Correctional Facility ☐ Other: _____

SECTION I - PERSONAL INFORMATION

1. Name _____ (Last) _____ (First) _____ (MI)

2. Sex ☐ Male ☐ Female

3. Street Address

4. Date of Birth ____ / ____ / ____ Month / Day / Year

5. City, State, Zip Code

6. County

7. Residency
   a. How long have you lived at the above address? _____ Years _____ Months
   b. Is this your principal place of residence? ☐ Yes ☐ No

NOTE: Two (2) proofs of residency MUST accompany this application. See Instructions.

8. Immigration Status
   a. Are you a U. S. citizen? ☐ Yes ☐ No **If yes, attach proof of citizenship (birth certificate, passport, voter registration, other).**
   b. Are you a legal alien? ☐ Yes ☐ No **If yes, attach copy of Alien Registration Card.**

9. Applicant's Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

10. Spouse's Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

11. Race/Ethnicity
   ☐ White (non-Hispanic) ☐ Hispanic ☐ American Indian/Aleutian/Native Alaskan/Eskimo
   ☐ Black (non-Hispanic) ☐ Asian/Pacific Islander ☐ Other

12. Marital Status
   ☐ Single ☐ Separated * ☐ Widowed
   ☐ Divorced ☐ Married **See Instructions*

13. Has your marital status changed in the last year?
   ☐ Yes - Date: ____ / ____ / ____ Month / Day / Year
   ☐ No

14. How many people live in your household? _____

NOTE: See Instructions for Definition of Household

SECTION II - HOUSEHOLD INCOME

In Column A, enter your ACTUAL HOUSEHOLD income, from all sources, for last year. In Column B, enter what you EXPECT your HOUSEHOLD income will be, from all sources, for the current calendar year. If your income from any of the sources listed below was "0" last year or is expected to be "0" this year, enter "0" in that column. Enter ONLY whole dollar amounts ($), do not list cents (c). DO NOT LEAVE ANY BLANKS!

15. Sources of Income *Attach additional sheet, if necessary.*	**COLUMN A 20____ Last Year Annual Income**		**COLUMN B 20____ Current Year Annual Income**		**FOR STATE USE ONLY**	
	(1) Applicant/ Spouse	**(2) Others**	**(1) Applicant/ Spouse**	**(2) Others**	**A / S**	**O**
Salary (Before Payroll Deductions)						
Unemployment Benefits						
Social Security Benefits (Net)						
Medicare Part B Annual Premium						
Pension Benefits (Identify in Section IV)						
Interest and Dividends						
Net Rental Income (After Expenses)						
Additional Income (Specify):						
TOTAL ANNUAL INCOME (FOR EACH COLUMN)						

16. Did you and/or any member of your household file a Federal, State or City Income Tax return last year?

☐ Yes * ☐ No

* If Yes, submit copies of the signed returns, including any and all attached schedules, with this application.

17. Have you applied for or are you currently receiving the following? (Check ALL that apply)

Applied For	**Receiving**	
☐	☐	AFDC
☐	☐	Food Stamps
☐	☐	Housing Assistance
☐	☐	Welfare
☐	☐	Social Security Insurance
☐	☐	Social Security Disability Insurance (see Instructions)
☐	☐	Unemployment Compensation
☐	☐	Worker's Compensation

SECTION III - EMPLOYMENT STATUS

18. What is your current employment status?

☐ Full time (35 or more hours per week) ☐ Part time(less than 35 hours per week) ☐ Not employed

19. Are you medically UNABLE to work?

☐ Yes ☐ No

SECTION IV - INSURANCE COVERAGE

20. Do you and/or your spouse receive a salary or pension?

☐ Yes * ☐ No ** If Yes, provide the following information:*

Name of Company, Employer or Union _____

Address of Above _____

21. What type(s) of health insurance coverage do you have? (Check ALL that apply)

☐ Private Insurance * *If checked, complete information below.*

☐ Medicare A (Hospital Insurance) (Medicare #: __ __ __ __ __ __ __ __ __ __ __ __)
(Effective Date: _____ / _____)

☐ Medicare B (Medical Insurance) (Medicare #: __ __ __ __ __ __ __ __ __ __ __ __)
(Effective Date: _____ / _____)

☐ Medicaid (Medicaid #: __ __ __ __ __ __ __ __ __ __ __ __)

☐ Municipal Welfare

☐ No Health Insurance Coverage

FOR STATE USE ONLY

* Private Insurance Information: **[NOTE: You must include a photocopy of the front and back of your insurance card(s).]**

Insurance Carrier _____ Policy No. _____

Address _____

If provided by Union or Employer:

Union/Employer _____

Address _____

Type of Coverage: ☐ Major Medical Plan ☐ Prescription Plan ☐ Other (Specify): _____

21a. Are you currently receiving prescription drug benefits under the Family Care Program?

☐ Yes ☐ No

22. Do you have insurance coverage for HIV/AIDS prescription drugs?

☐ Yes ☐ No

If yes: What is the co-pay amount? _____ What is the deductible? _____

*** If Yes, indicate why you are applying for ADDP:**

☐ One or more HIV/AIDS prescriptions are not covered.

☐ Expenses have exceeded insurance plan limits.

☐ Copayment for HIV/AIDS prescriptions not covered by insurance.

☐ Other limitations on coverage or payment, specify: _____

SECTION V - CERTIFICATION AND AUTHORIZATION BY APPLICANT

IMPORTANT - THE FOLLOWING CERTIFICATION AND AUTHORIZATION MUST BE SIGNED.

1. I certify that the information above is true and accurate to the best of my knowledge.
2. I will notify the Program immediately if my/our income rises above legal limits (as stated in the Instructions); if I move from New Jersey; or if I become Medicaid/Welfare/PAAD eligible.
3. I authorize the release of information necessary to determine my ADDP eligibility from the records in possession of the Social Security Administration, Internal Revenue Service and New Jersey Division of Taxation, employers, banks and others as the need arises. I authorize my physician to release information concerning prescriptions which have been paid on my behalf by the AIDS Drug Distribution Program.
4. I understand that I may be visited by representatives of the AIDS Drug Distribution Program in order to verify my/our eligibility and determine availability of other prescription coverage and I authorize such visitations.
5. I hereby assign to the State of New Jersey any right to drug benefits to w hich I may be entitled under any other plan of assistance or insurance or from any other liable third party.
6. I understand that the AIDS Drug Distribution Program is entitled to repayment for incorrectly provided benefits. I further understand that I will be held liable for any ADDP benefits which are determined to have been incorrectly provided on my behalf.
7. **I understand that the AIDS Drug Distribution Program reserves the right to limit enrollment based upon availability of funds.**

23. Signature or Mark of Applicant	24. Date
25. Signature or Mark of Spouse, If Married	26. Telephone Number of Applicant ( ) -
27. Person to Contact if Questions Arise	28. Telephone Number of Contact Person ( ) -